BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: **SARITA L. BENNETT, D.O., L.M.**
License Numbers: **0102-202731**
0129-000096
Case Numbers: **204493, 200947, 183506**

ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met on October 14, 2021. The purpose of the meeting was to receive and act upon information indicating that Sarita L. Bennett, D.O., L.M., may have violated certain laws and regulations relating to the practice of osteopathic medicine and midwifery in the Commonwealth of Virginia, as more fully set forth in the "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the licenses of Sarita L. Bennett, D.O., L.M., to practice osteopathic medicine and midwifery in the Commonwealth of Virginia are SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

Jennifer L. Deschenes

FOR William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 10/14/2021

STATEMENT OF ALLEGATIONS

The Board alleges that:

1. At all times relevant hereto, Sarita L. Bennett, D.O., L.M. ("Respondent"), was licensed to practice osteopathic medicine and midwifery in the Commonwealth of Virginia

2. Beginning in or about 2016, Respondent established and practiced midwifery at Winding River Birthing Center (previously known as Waterflow Midwifery and Integrative Medicine ("Birthing Center").

3. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) in her care and treatment of Patient A, a 40-year-old female with four prior births who presented for prenatal care on or about August 16, 2016, at approximately 35.6 weeks gestation. Specifically:

a. Respondent violated 18 VAC 85-130-81(B) and (C) of the Regulations Governing the Practice of Midwifery ("Midwifery Regulations") in that although Patient A informed Respondent that she had not had any prenatal care until late in her pregnancy and had not had any testing for gestational diabetes, and although the result of Patient A's 35-week one-hour glucose tolerance test was an elevated 157, Respondent failed to provide Patient A with a written disclosure of the risks related to home birth for a patient with significant glucose intolerance and to provide options for consultation and referral to a physician for this risk factor.

b. Respondent failed to order additional blood testing or document the estimated fetal weight to determine the ongoing risks presented by Patient A's abnormal glucose level. According to subsequent hospital records, the infant was macrosomic: his weight on the date of birth was 11 pounds, 4.3 ounces.

c. On or about September 18, 2016, at approximately 1:30 a.m., Patient A went into labor, which, according to Respondent's records, lasted six hours and forty-five minutes. According to a written statement provided to an investigator for the Department of Health Professions ("DHP"), Respondent observed the presence of meconium, and according to subsequent hospital records, meconium was found, but Respondent failed to document presence of meconium, in violation of 18 VAC 85-130-100(C) of the Midwifery Regulations and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic.

d. Respondent violated 18 VAC 85-130-120(A) of the Midwifery Regulations in that she failed to immediately transfer care in an emergent situation during delivery. Specifically, according to Respondent's records, she noted occult cord prolapse as the infant crowned and shoulder dystocia upon birth of the head. According to subsequent hospital records, records provided by Respondent showed that the shoulder dystocia lasted for eight minutes. Upon delivery, Respondent documented the infant's Apgar scores as 1, 3, and 5 at one, five and ten minutes, respectively. She noted that the infant showed no respiratory effort, and had no response to stimuli and limp muscle tone. She documented that she commenced CPR and positive pressure ventilation within 30 seconds of birth. The resuscitation effort continued for approximately 15 minutes before Respondent called emergency medical services ("EMS").

e. Upon arrival to the hospital, the infant was noted to be in respiratory distress and hypothermic, with a heart rate of 70. He underwent extensive inpatient treatment and, upon discharge on or about October 1, 2016, his active problems included enteral feeding due to tachypnea, moderate hypoxic ischemic encephalopathy, respiratory distress, meconium aspiration syndrome, hyponatremia, and seizures.

4. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), and (16) in her care and treatment of Patient B, who presented for prenatal care on or about July 1, 2016, at 12.5 weeks gestation. Specifically:

a. On or about January 21, 2017, Patient B began labor, which lasted for approximately 11 hours. Although Respondent recorded the fetal heart rates 60 seconds during and after contractions, she failed to document the intensity of the contractions, or the stage of labor at which the fetal heart rates were noted, all of which made it difficult to determine whether transfer was necessary to initiate assisted delivery.

b. Respondent documented that the infant was delivered at approximately 2:53 p.m. with nuchal cord wrapped five times around the neck. She was not breathing. According to Respondent's records, the heart rate was 100 at crown and continued to drop. Although Respondent recorded that the infant's heart rate went up to 80 after resuscitative efforts, she failed to document the lowest heart rate.

c. According to hospital records, upon arrival at the home, EMS performed CPR for approximately 20 minutes and then transported the infant to a local hospital emergency department, where she was intubated. She was then transferred to the NICU at another hospital. Despite intensive supportive measures, the infant expired on January 22, 2017. The cause of death was documented as hypoxic ischemic injury secondary to nuchal cord.

5. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) in her care and treatment of Patient C, who presented for prenatal care on or about February 22, 2017 at 9.4 weeks gestation. Specifically:

a. Respondent violated 18 VAC 85-130-81(B) and (C) of the Midwifery Regulations in that although Patient C informed Respondent that her prior pregnancy had resulted in delivery by

cesarean section and that she wished to proceed with vaginal birth after cesarean ("VBAC"), Respondent failed to provide Patient C with a written disclosure of the risks to both mother and infant posed by trial of labor after cesarean ("TOLAC") or to request and review records of Patient C's previous pregnancy.

b. Respondent violated 18 VAC 85-130-120(A)(1) of the Midwifery Regulations in that she failed to immediately transfer care in an emergent situation upon delivery. Specifically, according to Respondent's records, on or about September 30, 2017, Patient C went into labor. She arrived at the Birthing Center at 5:30 p.m. and the infant was delivered at 8:48 p.m. Respondent documented that the infant had no respiratory effort, did not respond to stimuli, and was limp, and that her extremities were blue. Respondent attempted resuscitation via chest compressions and positive pressure ventilation. Although she failed to document how long these efforts occurred, Respondent's records indicate that she called EMS at 9:09 p.m., approximately 21 minutes after the infant was delivered (according to EMS records, the call was made at 9:12 p.m.).

c. According to hospital records, the infant suffered from severe hypoxic ischemic encephalopathy and expired after birth.

6. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) in her care and treatment of Patient D, a 33-year-old female with a prior cesarean section who presented to Respondent for prenatal care on or about May 16, 2017 at 11.4 weeks gestation. Specifically:

a. Respondent violated 18 VAC 85-130-81(B) and (C) of the Midwifery Regulations in that although Patient D informed Respondent that her prior pregnancy had resulted in delivery by cesarean section and that she wished to proceed with VBAC, Respondent failed to provide Patient D with a written disclosure of the risks to both mother and infant posed by TOLAC or to request and review records of Patient D's prior pregnancy. Further, although she documented that Patient D's BMI

was 35.6 pre-pregnancy, Respondent failed to provide Patient D with a written disclosure of the risks to both mother and infant posed by a BMI of 30 or greater.

b. An ultrasound conducted by another practice at 36 weeks gestation, on or about October 30, 2017, revealed that the fetus was presenting in breech position with nuchal cord, at which time Respondent appropriately transferred Patient D's care to a hospital. On November 14, 2017, hospital records show that the fetus was in vertex position, and Patient D returned to Respondent's care. Despite the prior breech presentation, Respondent failed to provide Patient D with a written disclosure of the risks to both mother and infant posed by position presentation other than vertex at term or while in labor, as required by 18 VAC 85-130-81(C) of the Midwifery Regulations.

c. Respondent violated 18 VAC 85-130-120(A)(1) of the Midwifery Regulations in that she failed to immediately transfer care in emergent situations that arose during Patient D's labor and after delivery. Specifically:

i. According to Respondent's records, on December 13, 2017, Patient D's membranes ruptured at approximately 12:15 a.m. According to Patient D's written statement to the DHP investigator dated February 12, 2018, Respondent arrived at the home but the labor stalled, and Respondent left the home. The labor then progressed, and Respondent returned to Patient D's home at 10:00 p.m. on December 13, 2017 and found, as she recorded, "surprise! At introitis." At 10:42 p.m., Respondent noted that the fetus was again in breech position, with the buttocks emerging. Despite this high-risk position, Respondent decided to proceed with the delivery at home. According to Patient D, Respondent told her that she could be transported to the hospital, but there was a good chance she would be delivering in an ambulance with EMS workers who may or may not be experienced with breech delivery and that the best course of action was for her to continue with the birth at home.

ii. According to Respondent's records, the infant was fully delivered at 11:22 p.m. on December 13, 2017. He was noted to be apneic, and Respondent performed positive pressure ventilation for approximately 30 minutes commencing at 11:22 p.m. In a statement to the DHP investigator, Respondent stated that she kept the umbilical cord unclamped in order to improve the infant's oxygenation and blood supply; when the placenta was delivered, the infant's heart beat stopped and Respondent started chest compressions and called EMS. According to Respondent's records, EMS was contacted at 12:14 a.m. on December 14, 2017. Patient D and the infant arrived at the hospital emergency department with the infant at 12:50 a.m. on December 14, 2017. The infant was pronounced deceased at 1:08 a.m. on December 14, 2017.

7. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) in her care and treatment of Patient E, a 27-year-old who presented to Respondent for prenatal care on or about October 3. 2019 at 11 weeks gestation. Specifically:

a. Respondent violated 18 VAC 85-130-81(C) of the Midwifery Regulations as follows: on or about October 26, 2019, Patient E went into labor. At approximately 11:00 p.m., according to Respondents' records, an ultrasound indicated that the infant was presenting in breech position. Respondent made the decision to continue with the labor at the birthing center rather than transferring Patient E's care. However, in the almost four hours between discovery of the breech presentation and the delivery of the infant's buttocks, she failed to provide Patient E with a written disclosure of the risks to both mother and infant posed by position presentation other than vertex while in labor.

b. Although Respondent recorded the fetal heart rates periodically, she failed to note whether the fetal heart rate was measured before, during, or after contractions. She also failed to document any accelerations, decelerations, or variability. Finally, she failed to document the intensity of

the contractions, or the stage of labor at which the fetal heart rates were noted, all of which made it more difficult to determine whether transfer was necessary to initiate assisted delivery.

c. Respondent violated 18 VAC 85-130-120(A)(1) of the Midwifery Regulations in that she failed to transfer care of the infant despite his respiratory distress at delivery. Specifically, Respondent documented that Patient E labored until 2:49 a.m. on October 27, 2019, when the infant's buttocks emerged. The infant was fully delivered at 3:00 a.m., 11 minutes after his buttocks had emerged. Respondent noted that he was not breathing and that she started chest compressions at 3:01 a.m. and provision of oxygen at 3:04 a.m. She documented that the infant was breathing at 3:25 a.m. Despite having to provide resuscitative care to the infant for 14 minutes, Respondent allowed the parents to return home with the infant.

d. Respondent provided post-natal care to Patient E's infant for approximately 28 days. Respondent failed to refer care of the infant to a pediatrician or pediatric neurologist when he displayed risks for developmental delays, including plagiocephaly; feeding concerns including no suck/swallow reflex, aspiration of milk, and spitting up; seizures; passing out; and increased muscle tone and agitation.

e. A brain MRI of the infant conducted at a hospital on November 26, 2019 revealed severe subacute hepatic ischemic encephalopathy. In addition, hospital records indicate that the infant suffered other complications including bilateral hip dysplasia; poor state regulation; fibromatosis colli; and hearing deficiency.

e. Respondent violated 18 VAC 85-130-100(C) of the Midwifery Regulations and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic in that although Respondent indicated in a statement to the DHP investigator that a motor vehicle accident, which occurred on or about June 16, 2020, and a dental infection shortly

before labor during Patient E's pregnancy could have contributed to the infant's difficulties, Respondent failed to document these events or any discussion regarding possible resulting complications in Patient E's record.

8. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) in her care and treatment of Patient F, a 29-year-old with four prior cesarean sections who presented for prenatal care on October 24, 2019, at 14 weeks gestation. Specifically:

a. Respondent violated 18 VAC 85-130-81(B) and (C) of the Midwifery Regulations in that although Patient F informed Respondent that four of her prior pregnancies had resulted in delivery by cesarean section and that she wished to proceed with VBAC, Respondent failed to provide Patient F with a written disclosure of the risks to both mother and infant posed by TOLAC or to request and review records of Patient F's prior pregnancies. In addition, Respondent noted that Patient F weighed 205 pounds at her first examination on October 24, 2019, and, according to other medical records, Patient F's height was 5 feet, 2 inches, for a Body Mass Index ("BMI") of 37.5. Respondent failed to provide Patient F with a written disclosure of the risks to both mother and infant posed by a maternal BMI equal to or greater than 30.

b. Patient F resided in another state, a three-hour drive from the Birthing Center. Nevertheless, Respondent assumed responsibility for delivery of Patient F's infant at the Birthing Center.

c. Respondent appropriately referred Patient F to Dr. X, a specialist in maternal fetal medicine, for an ultrasound to evaluate the thickness of Patient F's uterine scar and the placental placement. Based on the ultrasound, taken on March 13, 2020, Dr. X determined that Patient F had a less than 1% probability of a uterine defect during TOLAC. However, in an interview with a DHP investigator on June 8, 2020, Dr. X stated that Respondent failed to notify him that Patient F had had

four prior cesarean sections, and that if he had known of the number of prior cesareans, he would have told Patient F not to consider TOLAC at a birthing center.

d. Respondent violated 18 VAC85-130-120(A)(1) of the Midwifery Regulations in that she failed to immediately transfer care in an emergent situation during labor. Specifically, in the morning on or about April 6, 2020, Patient F experienced spontaneous rupture of membranes at her home out of state. She and her husband drove to the Birthing Center and spent the night there. In interviews with a DHP investigator on June 4, 2020, Patient F and her husband related that Patient F experienced intense pain throughout the early morning of April 7, 2020. Meconium was noted, but Respondent failed to inform Patient F of the significance of this finding. Patient F related that Respondent informed her that she was not satisfactorily dilated and that she would like to see Patient F in a hospital setting. However, Patient F related that Respondent failed to convey the urgency of the situation and even suggested that Patient F could return to a hospital in her home state. Although Patient F related that Respondent had initially informed her she would accompany Patient F to the hospital in the event of an emergency, on April 7, 2020, Respondent stated that she could not accompany Patient F to the hospital. According to the parents, Respondent provided little guidance and left to them the decision of which hospital to go to. The parents related that because Respondent indicated it would be safe, they left the Birthing Center and returned to their home. When they departed, Respondent did not inquire what hospital they intended to go to and said they should have the hospital call if there were any questions.

e. Respondent violated 18 VAC 85-30-100(D) of the Midwifery Regulations in that although she indicated that she encouraged Patient F to go to a local hospital and that Patient F refused this advice, she failed to clearly document Patient F's decision. According to Respondent's records, the events of April 7, 2020, occurred in the following fashion:

1:35 a.m.:	in bed – resting between contractions
8:05 a.m.:	stronger, frequent contractions
8:25 a.m.:	meconium in water – not fresh, not particulate
9:45 a.m.:	meconium – fresh, particulate
10:00 a.m.:	50%/ 1-2cm/ -4 station/ + meconium
10:20 a.m.:	discussed concerns re: meconium and internal exam
10:40 a.m.:	advised making plans for cesarean delivery
11:15 a.m.:	choosing to transfer to Maryland hospital – records given

Respondent later amended the record of events to indicate that she spoke with Dr. X about a possible transfer of Patient F's care but that he could not accept Patient F due to COVID restrictions. However, in his interview with the DHP investigator, Dr. X stated that when he received Patient F's ultrasound referral from Respondent in March 2020, he informed Respondent that he would not be her backup for care. In addition, Dr. X stated that on April 7, 2020, when Respondent contacted him, he informed her that the hospital with which he was associated had very strict requirements for unassigned OB patients and that he would not be able to admit Respondent's patient because she was not his patient. Dr. X stated that he told Respondent that another practice was taking unassigned call and she responded that that would not work because that practice had previously reported her to the Board. On or about April 8, 2020, Respondent further amended the record of events to state that Patient F had declined transport to a local hospital.

f. At approximately 10:53 p.m. on April 7, 2020, the father called 911 from their home, reporting that the infant's arm had emerged. Shortly thereafter, Patient F arrived at the emergency department of a nearby hospital via EMS. Hospital records indicate that upon arrival, the fetus was noted to have an arm hanging out of the cervix that was blue, and there was no discernible fetal heart tone. The deceased infant was delivered by emergency cesarean section at 11:39 p.m. on April 7, 2020.

g. The hospital's fetal death certificate indicated that a histological placental examination was performed and that the cause or condition that most likely began the sequence of events resulting in the death of the fetus was "complications of placenta, cord, or membranes – rupture

of membranes prior to onset of labor." The certificate further indicated that Patient F's previous four cesareans were a significant cause or condition that contributed to the fetal death.

9. Respondent violated Virginia Code § 54.1-2915(A)(3), (4), (13), (16), and (18) and 18 VAC 85-130-80(A), 18 VAC 85-130-100(C) and (D), and 18 VAC 85-130-110(A)(1) of the Midwifery Regulations in that at the initiation of care to Patients A, B, C, D, E, and F, Respondent failed to disclose and properly document disclosing (as confirmed by the patient's signature) her plan of care for the patient, as well as certain information required for informed consent to midwifery care and home birth, including (i) her written protocol for medical emergencies, including hospital transport, particular to each patient; (ii) a statement as to whether she had hospital privileges; (iii) a copy of the regulations governing the practice of midwifery; (iv) an explanation of the Virginia Birth-Related Neurological Injury Compensation Fund and a statement that licensed midwives are currently not covered by the fund; and (v) a description of the right to file a complaint with the Board of Medicine and with the North American Registry of Midwives and the procedures and contact information for filing such complaint.

10. Respondent violated Virginia Code § 54.1-2915(A)(1) and (16) in that although the "Informed Consent" form that Respondent did provide to the patients stated that Respondent would accompany patients to the nearest appropriate medical facility if they transferred care during labor, birth, or immediate postpartum, Respondent did not accompany Patients A, B, C, or D to the medical facilities where care of their infants was transferred due to complications upon delivery.

See Confidential Attachment for the names of the patients referenced above.

Jennifer L. Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

10/14/2021
Date